

Part B:

To be completed by Physician or other
Licensed Health Care Professional
***Professional Verification of Functional Limitation
Affecting Mobility for Use in Determining
ADA Complementary Paratransit Eligibility***

Dear Licensed Health Care Professional:

You have been requested by your patient/client to provide information to the MetroWest Regional Transit Authority (MWRTA), regarding his/her disability and its impact on his/her ability to use our transit services. Federal law requires that the MWRTA provide paratransit services to persons who cannot use our fixed route bus service independently.

Please understand that the law is quite strict in defining who is eligible for this specialized service. A person must have an actual physical or mental functional limitation, which prohibits his/her independent use of accessible fixed route public transportation. Just the diagnosis of a potentially limiting illness or condition is not sufficient.

The information that you provide describing the physical and or mental capabilities of this person will allow us to make an appropriate evaluation in keeping with the requirements of the law and the best interests of the applicant. **Please be as specific as possible when describing the disability as well as the limitations due to the disability.** *ALL information on this form will be kept confidential.*

Please return this form, along with the application to: The MetroWest RIDE, 37 Waverley Street, Framingham, MA 01702, Attention: ADA Director, as soon as possible. Processing of this person's application cannot be completed until we receive this information from you.

Thank you for your assistance.

Please type or print.

Your name: _____

Office address: _____

City: _____ Zip Code: _____

Office Phone number: () _____

Patient/client name: _____

1. Capacity in which you know the applicant:

2. How does this person's condition cause functional limitations that adversely affect his/her mobility?

3. Is this condition temporary? Yes { } No { }

If yes, expected duration.

Condition will last until approximately _____, 20_____

If this person has a condition that adversely affects his/her mobility, please answer the following questions.

4. How many city blocks can he/she walk without assistance? _____

5. If he/she uses a mobility aid, how many city blocks can he/she travel without assistance using this aid? _____

6. How many 12 inch high steps can he/she climb without assistance, whether using a mobility aid or not? _____

7. How long can he/she stand and wait without support or sitting? _____

8. To your knowledge, does this person require the aid of a personal care attendant, when traveling by public transit? Yes { } No { }
9. Does this person use a wheelchair? Yes { } No { }

If this person has vision impairment, please complete the following:

10. Visual acuity with best correction:

Right eye _____ Left eye _____ Both eyes _____

11. Visual fields:

Right eye _____ Left eye _____ Both eyes _____

12. Can this person read informational signs? Yes { } No { }

13. Can this person navigate independently, despite his/her visual impairment? Yes { } No { }

If no, please explain:

If this person has a cognitive disability, please complete the following:

Is he/she able to:

14. Site names, addresses, and telephone numbers upon request? Yes { } No { }

15. Recognize a destination or landmark? Yes { } No { }

16. Deal with unexpected situations, or unexpected changes in routine? Yes { } No { }
17. Ask for, understand, and follow directions? Yes { } No { }
18. Safely and effectively travel through crowded and/or complex facilities Yes { } No { }

19. Please describe any other functional limitation(s) affecting this person's mobility that is not described above.

Signature _____ **Date** _____

MA License # _____